**Dr NAI'M M MOOLA**
Integrative **Psychiatrist**
**BMedSc, MBChB, FCPsych(SA), MMedPsych(UP)**
**PR: 0343285**

FILE NO. _____

**PARTICULARS OF PATIENT**

SURNAME _____ NAME _____ INITIALS _____ TITLE _____

GENDER _____ DATE - BIRTH _____ ID NO. _____

RESIDENTIAL ADDRESS _____

TEL: (H) _____ (W) _____ (M) _____

E-MAIL _____Principal member / dependent on scheme?_____

I hereby accept that email ☐ YES ☐ NO
and/or sms ☐ YES ☐ NO messages may be sent to me in order to confirm appointments and convey general information of the practice and my healthcare.

OCCUPATION _____ EMPLOYER (CO NAME) _____

EMPLOYER CONTACT DETAILS_____
(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)

REFERRED BY _____

NAME, ADDRESS & TEL NO. OF A FAMILY MEMBER / FRIEND: _____

_____
(for account purposes should we be unable to contact you)

**MAIN MEMBER OF MEDICAL SCHEME**
(please note that all adults are responsible for their own accounts, even if they are dependents on someone else's scheme)

SURNAME _____ NAME _____ INITIALS _____ TITLE _____

GENDER _____ DATE OF BIRTH _____ ID NO. _____

ADDRESS _____

TEL: (H) _____ (W) _____ (M) _____

OCCUPATION _____ EMPLOYER (CO NAME) _____

MEDICAL SCHEME _____ NO. _____

E-MAIL ADDRESS _____

## Terms and Conditions of the Practice

By signing this form, you acknowledge that you have understood and agreed to the following:

1) That you have received a copy of the terms and conditions (provided separately) and have had an opportunity to ask questions on aspects thereof that you were not certain about.
2) To abide by the terms and conditions of the practice, in particular the provisions on the payments of accounts.
3) To always ask, even after you have left the practice if you were uncertain about something. If you keep quiet, practice staff and the doctor will assume that you have understood everything and ae in agreement with any processes, consents, policies or forms.
4) **If you do not keep your appointment (for any reason whatsoever, apart from emergencies) and you have not let us know at least 48 hours before the appointment, <u>we reserve the right to charge you (not your medical scheme) a portion of the consultation fee as a cancellation fee</u>, as we have kept the slot open for you and could not assist another patient.**

_____ _____ _____
SIGNATURE DATE WITNES